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December 3, 2014

Members, Joint Standing Committee on Health and Human Services  
c/o Legislative Information Office  
100 State House Station  
Augusta, ME 04333-0100

**RE: Resolve 2013, Chapter 91, Resolve, Directing the Department of Health and Human Services to Review the Use of Restraint and Seclusion of Children in a Hospital or Children's Home**

Dear Members of the Joint Standing Committee on Health and Human Services:

Resolve Chapter 91 required the Department of Health and Human Services to undertake a review of the use of restraint and seclusion in the State Psychiatric Hospitals. In addition, the resolve asks the Department to invite non-state institutions to provide further information on restraint and seclusion across the state. DHHS met internally, bringing together the multiple offices with mental health expertise and met externally with hospital representative from around the State to determine the best approach for acquiring the requested information. While we were able to collect data, the review of the restraint and seclusion data proved to be challenging. Policies vary and while all hospitals collect data, the data is not always comparable.

Three major barriers presented challenges for the group:

1. The hospitals have different operational definitions of seclusion and restraint which impact what they collect, how they characterize various events, and what is considered reportable. There are similarities among the various policies and procedures regarding seclusion and restraint but the differences are significant and do not lead to data comparison across hospitals.
2. The reporting requirements and definitions set forth from data collection agencies are different for the hospitals involved. The state psychiatric hospitals use NRI but other hospitals may use other data agencies or are not required to report their restraint and seclusion data for the mental health services they provide.
3. The regulatory requirements from Center for Medicaid and Medicare Services, Maine DHHS, Division of Licensing and Regulatory Services and The Joint Commission do not necessarily align with the reporting definitions from the various data collection agencies.

Page 2  
December 3, 2014  
Resolve 2013, Chapter 91

Attached is a table containing the seclusion and restraint data we were able to collect, as well as the seclusion and restraint policies that Riverview Psychiatric Center and Dorothea Dix Psychiatric Center each adhere to in daily operations.

It is undetermined at this time whether the state hospitals, Acadia, Spring Harbor and the acute care hospitals that provide inpatient psychiatric care can develop the same criteria or whether variations in reporting can be aligned. The Maine Hospital Association's Mental Health Committee has agreed to examine the reporting differences to determine whether a more consistent reporting approach is possible. Those findings will be reported to the Health and Human Services Committee when they are available.

If you have further questions or concerns related to this review, please contact Ricker Hamilton at [ricker.hamilton@maine.gov](mailto:ricker.hamilton@maine.gov).

Sincerely,



Mary C. Mayhew  
Commissioner

MCM/klv

Attachments A-D

ATTACHMENT A

**Percentage of Clients Secluded**

by Quarter, by Calendar Year, percentage of Clients Secluded at Least Once

Hospital	2011				2012				2013				2014	
	1st	2nd	3rd	4th	1st	2nd	3rd	4th	1st	2nd	3rd	4th	1st	2nd
Acadia*														
Dorothea Dix	4.37	4.74	3.24	2.54	1.96	2.38	1.13	2.79	3.36	0.59	1.88	0.60	3.21	4.75
Riverview	4.14	4.79	3.00	3.01	5.11	6.21	5.61	8.01	6.33	6.62	7.64	11.19	8.01	7.35
Spring Harbor					5.57	5.23	3.43	4.27	5.57	5.23	3.17	3.93	2.47	2.70
St. Mary's**														
Maine General**														
S. Me. Health Care									0.00	0.00	0.00	62.00%	2.59	0.83

\*Acadia reports no use of seclusion

\*\* St. Mary's does not report percentages

\*\*Maine General does not report percentages

**Seclusion Hours**

by Quarter, by Calendar Year, per 1,000 inpatient hours

Hospital	2011				2012				2013				2014	
	1st	2nd	3rd	4th	1st	2nd	3rd	4th	1st	2nd	3rd	4th	1st	2nd
Acadia*														
Dorothea Dix	0.16	0.31	0.23	0.12	0.16	0.07	0.03	0.58	0.16	0.02	0.10	0.01	0.38	0.41
Riverview	0.25	0.90	3.76	0.18	0.42	8.00	0.88	3.01	1.42	3.49	1.48	9.30	4.21	0.76
Spring Harbor					0.42	0.50	0.60	0.46	0.44	0.44	0.62	0.22	0.12	0.31
St. Mary's	31.2	6.67	3.58	3.6	16.78	99.58	29.81	2.29	4.09	2.28	0.27	5.13	32.06	12.65
Maine General							0.58	2.24	1.66	2.78	2.15	4.65	4.51	3.56
S. Me. Health Care									0.00	0.00	0.00	0.04	1.22	0.25

\*Acadia does not use seclusion

## ATTACHMENT B

### Percentage of Clients Restrained

by Quarter, by Calendar Year, percentage of clients restrained at least once

Hospital	2011				2012				2013				2014	
	1st	2nd	3rd	4th	1st	2nd	3rd	4th	1st	2nd	3rd	4th	1st	2nd
Acadia	4.10	4.00	3.90	3.20	3.30	4.60	6.20	3.40	6.40	5.40	4.50	6.70	6.90	5.50
Dorothea Dix	6.34	8.03	7.28	6.65	4.43	3.47	3.42	3.86	6.10	3.93	2.44	3.84	6.51	8.15
Riverview	5.79	6.59	6.42	4.41	6.73	7.30	9.00	8.89	7.20	7.22	6.53	9.13	6.49	7.09
Spring Harbor					5.67	4.33	3.47	5.77	5.87	4.27	3.20	5.07	3.50	3.93
St. Mary's*														
Maine General**														
S. Me. Health Care									1.81	1.25	0.00	1.23	0.00	0.83

\*St. Mary's does not report percentages

\*\*Maine General does not report percentages

### Restraint Hours

by Quarter, by Calendar Year, per 1,000 inpatient hours

Hospital	2011				2012				2013				2014	
	1st	2nd	3rd	4th	1st	2nd	3rd	4th	1st	2nd	3rd	4th	1st	2nd
Acadia	0.10	0.02	0.04	0.08	0.05	0.04	0.03	0.02	0.04	0.12	0.05	0.06	0.05	0.11
Dorothea Dix	0.01	0.01	0.00	0.02	0.09	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.02
Riverview	0.03	0.05	0.02	0.02	0.02	0.09	0.36	0.46	0.54	0.60	0.45	0.70	0.30	0.12
Spring Harbor					0.45	0.16	0.27	0.32	0.48	0.22	0.28	0.18	0.15	0.32
St. Mary's	0.26	0.00	0.00	0.08	0.00	0.00	0.04	0.21	0.00	0.00	0.00	0.00	0.71	0.00
Maine General**							1.17	1.12	0.00	0.56	1.61	1.03	0.00	0.00
S. Me. Health Care									0.13	0.11	0.00	0.31	0.00	0.21

\*\*Maine General reports seclusion and restraint together from January 2011 through June 2012. It was not included for that reason.

ATTACHMENT C

**RIVERVIEW PSYCHIATRIC CENTER**

**FUNCTIONAL AREA:** Provision of Care,  
Treatment and Services

**POLICY No:** PC.12.10

**TOPIC:** Seclusion and Restraint Events

**AUTHORIZATION:**

\_\_\_\_\_  
Clinical Director

\_\_\_\_\_  
Director of Nursing

\_\_\_\_\_  
Superintendent

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**I. PURPOSE:**

- A. To establish hospital policy and procedural guidelines governing the use of seclusion and restraint interventions used for a patient who is at imminent risk of harming him/herself or others and no other less restrictive intervention is possible.
- B. To ensure patients are treated with safe practices, with dignity and respect, and to ensure patient's rights are protected in regard to the use of seclusion and restraints.
- C. Riverview Psychiatric Center (RPC) is striving to decrease the use of seclusion and restraint. Seclusion and restraints are considered emergency measures or interventions of last resort to protect patients in imminent danger of harming him/herself or others. The use of seclusion and restraint create significant risk for people with psychiatric disorders and for staff. These risks may include physical injury, including death, and the re-traumatization of people who have a history of trauma, loss of dignity and other psychological harm. Seclusion and restraint should be considered where an emergent safety need is identified and only after other less restrictive measures have failed. In light of these potential serious consequences, seclusion and restraint will be used only when there exists an imminent risk of danger to the individual or others and no other safe and effective intervention is possible.
- D. It is recognized that a rich and caring therapeutic milieu, which strives to enhance patient choice and self-determination is the most effective means to avoid the use of seclusion and restraint.

**II. POLICY:**

- A. Seclusion and restraints are considered emergency measures or interventions of last resort to protect patients in imminent danger of harming him/herself or

- others.
- B. The least restrictive seclusion/restraint method that is safe and effective will be administered at all times.
  - C. Seclusion and/or restraints will never be used for the purposes of discipline, coercion, active treatment, staff convenience or as a replacement for adequate levels of staff.
  - D. Seclusion/restraint is never part of a patient's treatment plan.
  - E. A PRN order for seclusion and/ or restraint is prohibited.
  - F. Only those physical holds or mechanical devices approved by the Riverview Behavioral Response Leadership Committee and Hospital Administration will be used to physically restrain a patient.
  - G. Definitions:
    1. Time Out: a voluntary intervention whereby the patient chooses to temporarily move from their immediate environment to a quiet environment and the patient is not prevented from leaving. If a seclusion room is utilized, the patient must be able to exit the room at will without staff intervention (unlocked). Since this intervention is voluntary, no physician's order is required.
    2. Escort Techniques: occurs when for the safety of the patient and/or others, the patient is encouraged to walk from one environment to another. The patient may or may not be physically assisted to walk from one environment to another. An assisted walk does not require a separate order for restraint. If patient becomes resistive then the assistance becomes a restraint hands on hold and requires all necessary appropriate procedures be followed.
    3. Seclusion: any involuntary confinement of a patient in a room or an area from which the person is physically prevented from leaving or believes they cannot leave.
    4. Blanket Release: Two blankets are positioned on the mattress in the single room care (SECLUSION) on the floor in an overlapping pattern. The patient is lowered and placed on the blankets. Staff swaddle patient with inner blanket, and repeat process with outer blanket. Staff then systematically, at the discretion of the leader, exit the SECLUSION. This technique was developed to facilitate the safe exit from the seclusion room by staff, while providing a safe method of temporarily reducing movement of the patient. Requires discretion or the leader overseeing the SECLUSION event.
    5. Restraint: Direct application of physical force to an individual, without the individual's permission, to restrict his/her freedom of movement. Restraint is any physical technique, physical/mechanical device, material or equipment attached to or adjacent to the patient's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body. Only those interventions, devices or holds approved by the Riverview Behavior Response Leadership Committee and Hospital Administration will be used to physically seclude/restrain a patient.

6. Drugs used as restraint: A medication used for the emergency control of behavior and is not a standard treatment for the patient's medical or psychiatric condition.
7. Clinical assessment for seclusion and restraint: assessment in which a physician substantiates through documentation in the medical record that the reason for a patient being placed in seclusion/restraint is in order to prevent harm to self or others.
8. Criteria / clinical justification for seclusion or restraint: behaviorally oriented criteria justifying the use of seclusion/restraint to prevent the patient from injuring themselves or others and when less restrictive interventions are inadequate, have been attempted and failed, unless a safety issues demand immediate physical response to prevent the behavior.
9. Emergency (behavioral health): An emergency is a situation where there is imminent risk of an individual physically harming themselves, staff, or others, when non-physical interventions are not viable, and safety issue demands immediate physical response to prevent injury to self or others. Note: Supplemental physical intervention response options will only be used in an emergency situation when there is imminent threat to, or of, loss of life.
10. Trained staff: includes physicians, licensed nursing staff and other direct care staff who have been trained in de-escalation techniques, and safe management of seclusion and restraints. Approved Restraints: Only behavioral and physical interventions strategies and restraint techniques approved by the Riverview Psychiatric Center Behavior Response Committee are to be used.

### III. PROCEDURE

Staff who have received RPC approved training in de-escalation and safe management of seclusion and restraint may participate in secluding or restraining patients.

#### A. Safety Needs and Hands on Intervention:

1. Prior to the initiation of any SECLUSION event, a Psych Stat Call should be placed if local unit staff is insufficient to handle.
2. Before hands-on intervention and/or placement in restraints, the RN who is directing the intervention shares the patient's unique safety needs with responding staff. The RN also informs the responding staff of any safety precautions that they should take during the hands-on interventions. All patients remain in their own clothing unless the clothing worn increases the risk of danger to self or others. The RN shall assess and evaluate the patient's condition every hour to assure safety and document same.
3. When a patient with a physical disability has a history of agitation leading to hands-on interventions, the safety needs of the patient are addressed in the treatment plan.
4. While in mechanical restraints, the patient is continuously observed under 1:1

direct visual contact.

5. While in seclusion, the patient is continuously observed under 1:1 visual contact for the first 1 hour. After the 1<sup>st</sup> hour, the continuous observation may be by visual contact or by camera, based on the clinical need of the patient. The doctor's order must reflect what the clinical need of the patient is at that time.
6. If, during a seclusion and/ or restraint or during an escort to seclusion and/ or restraint, a patient spits at involved staff, a protective spit hood may be used. In addition, a disposable oxygen mask may be placed on the patient to prevent the patient from spitting and/or biting. A washcloth or small towel may be held in front of the patient's face to block the spit as an alternative to the use of the oxygen mask. At no time should the cloth or towel be placed inside the patient's mouth or held against the patient's face. Staff must use universal precautions (gloves and mask).

B. Seclusion and/or restraint orders must be dated, timed and signed;

1. Not to exceed 4 hours for restraints, 4 hours for seclusion, and 30 minutes for hands on holds. Specify the type of Seclusion and/ or Restraint.
2. Identify alternative less restrictive measures attempted and the patient's response;
3. Specify the maximum amount of time limit in seclusion and/ or restraints, not to exceed limits cited above;
4. Behaviorally justify the use of seclusion and/ or restraints;
5. Identify the earliest conditions under which the patient may be released;
6. Identify target behaviors for Seclusion and/ or Restraint release;
  - i. Identify level of staff supervision and/or
  - ii. assistance required during free movement if it differs from 1:1 observation;
7. The specifics in the physician/ physician assistant/nurse practitioner's order and progress note provide the necessary documentation required for initiation of seclusion and/ or restraints;
8. The physician assistant/nurse practitioner contacts the attending physician or psychiatrist on call as soon as practical to consult about the order to use Seclusion and/or Restraint.
9. When a physician/ physician assistant/nurse practitioner is not immediately available, the registered nurse (RN) assesses the patient meets the criteria for seclusion/restraint (poses an imminent risk of harm to self or others) he/she may order placement in seclusion and/ or restraint pending immediate notification (no longer than thirty (30) minutes after initiation of intervention) of the physician/ physician assistant/nurse practitioner. The RN documents the clinical justification for seclusion and/ or restraint in the progress notes, charting the patient's behavior and assessment data based on the criteria above.

C. Following placement of the patient in seclusion and/ or restraint by the RN, the physician/ physician assistant/nurse practitioner personally evaluates the patient within thirty (30) minutes of initiating the seclusion and/ or restraint. The physician/ physician assistant/nurse practitioner documents the findings of the evaluation in a progress note. If the evaluation does not occur within thirty (30) minutes, the reason for the delay is documented in the patient's chart. The RN generates an incident

report for any delay in this medical evaluation.

D. The RN is authorized to carry out the physician/ physician assistant/nurse practitioner order for seclusion and/ or restraint.

E. Use of SECLUSION gown/suicide gown which is a tear resistant single-piece outer garment that is generally used to prevent an individual from forming a noose with the garment to commit suicide, is written in the physician/physician assistant/nurse practitioner's order.

F. Each initiation of seclusion or restraint requires a new order and the requirements restart (even if this occurs during the original time frame)

G. Prolonged Episodes of Seclusion and/ or Restraint:

1. Each extension of seclusion and/ or restraint requires a new physician/ physician assistant/nurse practitioner's order and will meet the same standards as outlined in above.
2. The total length of time in seclusion and/ or restraint is not to exceed twenty-four (24) hours. The Clinical Director or designee must review the need to continue seclusion and/ or restraint use longer. A medical assessment by the physician /physician assistant/nurse practitioner is done with this review. This medical assessment includes vital signs, nutrition, hydration, and treatment of any injuries. The physician/ physician assistant/nurse practitioner notifies the guardian of the medical assessment findings and treatment recommendations.

H. Notification, Ongoing Assessment & Documentation Requirements for Seclusion and/or Restraint:

1. The physician/ physician assistant/nurse practitioner or RN notifies the patient's guardian or representative as soon as possible of the need for seclusion and/ or restraint.
2. The patient's identified family member is notified promptly of the initiation of seclusion/restraint, in cases where the patient has consented to have family kept informed regarding his/her care and the family has agreed to be notified (the patient identifies a family member for contact during the safety assessment process, if no such person has been identified, this is documented on the safety assessment)
3. A Progress Note is written by the physician/ physician assistant/nurse practitioner's when seclusion and/ or restraint is started and for any extensions. The Progress Note must describe the rationale for seclusion and/ or restraint, with behavioral descriptions; precipitating factors and patient behavior prior to intervention and all less restrictive alternatives used including the patient's response.
4. The RN and Mental Health Workers (MHW) document the following information on the seclusion / restraint Monitor Sheet.
  - a. Rationale for seclusion and/ or restraint, with behavioral descriptions; precipitating factors and patient behavior prior to intervention;
  - b. All less restrictive alternatives used including the patient's response;
  - c. RN assessment at time of initiation and notification of attending

- provider;
- d. Assistance provided to the patient to help him/her meet the behavioral criteria for discontinuation of seclusion/restraint (e.g., ability to contract for safety, orientation to the environment, and/or cessation of verbal threats);
  - e. Evidence of continuous monitoring;
  - f. Description of patient behaviors every fifteen (15) minutes;
  - g. Offer of food and fluids and personal hygiene measures at least every 30 minutes and more frequently if necessary;
  - h. Sequential release (this is not done with highly agitated, assaultive patients) and exercise of extremities: circulation check every 15 minutes;
  - i. Ongoing nursing assessment by an RN and assessment for release hourly for seclusion and/ or restraints;
  - j. When the RN questions the need for the patient to stay in Restraint, the nurse will make an assessment prior to releasing patient. The RN assesses if the patient continues to pose a danger to self/others. If anytime during the release procedure, the patient is assessed not to need continued restraints, the RN will direct staff to release the patient from restraints. The RN documents the ongoing assessment data based on criteria outlined above.

#### I. Use of Mechanical Equipment to Transport patients in Extreme Behavioral Situations:

1. In general, the movement of combative patients is to be avoided because of potential risk of injury. However, in extreme behavioral situations, where all other physical, psychological or pharmacological interventions have failed or increased the risk of harm, the attending psychiatrist or his/her designee may direct and personally supervise the safe transport of patients, if this is medically indicated. A Scoop Stretcher with "Spider Strap" and Safety Transport Chair is available for use when Mechanical Equipment is deemed necessary to transport patients.
2. Guidance governing the use of mechanical devices in transport includes:
  - a. All efforts at psychological de-escalation, dispute resolution, appropriate pharmacological interventions and Riverview approved hold techniques for a minimum of 20 minutes have been made with non-resolution of the behavioral crisis. An emergency situation as defined in this policy may necessitate action prior to the completion of 20 minutes of physically holding as deemed necessary by the supervising medical staff;
  - b. Multiple attempts to verbally redirect the patient to walk, assisted or unassisted, to an alternative environment have been unsuccessful.
3. The PA or NP shall notify the on-call psychiatrist (if the event occurs after hours) who certifies the necessity for the use of the mechanical transport devices prior to the initiating the transport.
4. The medical staff member in attendance personally ascertains that the patient can safely be moved by sufficient numbers of staff trained in the use of mechanical transport devices and directly supervises any such transport.

J. Blanket release:

1. The Blanket Release will be used at the discretion of the Leader responsible for the oversight of the Seclusion Event, and applied by the staff that has been trained to perform the Blanket Release technique.
2. There will be an awareness of medical history (i.e. respiratory difficulties and physical impediments), and a nursing visual assessment of same. Careful observation by the nurse during and after the application of the Blanket Release is required.

K. Protective hoods may be used on patients that present or have previously demonstrated a propensity to spit or bite during a restraint application or when physically restrained. Protective spit hoods will only be utilized under the direct supervision of a Licensed Independent Practitioner (LIP) or a registered nurse. The use of the protective spit hood will be documented on the physicians order form. The protective spit hood will only be used in exceptional situations when a patient has a history of spitting and/or biting or is in the process of spitting and/or biting and will not be seen as a routine or standard procedure.

Debriefing:

1. Post Event Patient Debriefing:
  - a. The patient's guardian or representative may be present at the debriefing.
  - b. In the event that Seclusion and/ or Restraints are used late in the evening or at night, and if patient fatigue requires deferment of the debriefing, a copy of the full report of the incident will be given to the treatment team the following morning. The appropriate team members including the RN and physician or designee will convene the debriefing.
  - c. The patient's physician or designee will facilitate the debriefing.
  - d. The RN and physician or designee will complete and sign the Patient Debriefing Sheet "" including the patient's response to the use of seclusion and/ or restraints.
  - e. Modifications to the patient's Treatment Plan, as indicated, will be drafted and documented.
  - f. If the patient requests that a specific staff person not be present at the debriefing, that request will be honored. The issue will be addressed during the debriefing to formulate a plan for conflict resolution.
  - g. With permission from the patient, repeat users of seclusion and/or restraint may be referred to peer support to assist in collecting additional information that may be used to mitigate future events. The following may occur:
    - a. The treatment team, when appropriate will identify patients who are repeat users of seclusion and/or restraint
    - b. Treatment team will contact the peer support person assigned to the patient's unit to notify them of the need for additional support in developing a plan to mitigate future events
    - c. If the peer specialist and the patient agree to engage in developing a plan to reduce seclusion and/or restraint use it will be recorded in the medical record

- d. When the patient has a seclusion or restraint event, the charge nurse will notify the peer specialist on the next business day
- e. Within 48-72 hours of the seclusion or restraint, peer support will complete a patient debriefing to collect additional information about what led up to the event and document it in the medical record.

2. Post Event Staff Debriefing:

- a. The patient's RN or designee will conduct the debriefing with involved staff immediately following the use of seclusion and/ or restraint or any unusual event. An event with or without a Stat call requires a staff debriefing.
- b. Documentation of this debriefing will be included on the "Staff Debriefing/Stat Call Critique" form.
- c. The RN 4 or NOD/ADON is immediately notified of the use of restraint or seclusion or hands on holds.

M. Patient/Family Education:

1. Education regarding the hospital's philosophy and policy regarding restraint/seclusion is reviewed with each patient upon admission during the safety assessment.
2. Alternatives to seclusion/restraint are identified during the safety assessment.
3. A family member or significant other is identified for notification of seclusion/restraint intervention during the safety assessment. If none identified this is documented.
4. The RN provides education regarding the restraint episode for the patient and family.
5. The RN documents the teaching and patient/family response, along with the plan for follow-up education in the Progress Notes.
6. A **Safety Meeting** is held within 72 hours of any coercive event. The purpose of the meeting is to review the current safety plan, involve the patient in developing interventions to assist him / her to maintain safe behavior and identify "triggers" as well as individualized coping techniques that may assist him / her in the hospital as well as the community. Participants should include the psychiatrist, patient, RN, SW, MHW, & psychologist (if working with the patient) and Peer Support if patient wishes. Documentation of this meeting is headed and recorded in the progress notes as "Safety Meeting" and addresses, at minimum:
  - a. a brief description of event
  - b. changes made to the safety plan
  - c. medication / treatment compliance – review
  - d. any injuries incurred and what was done
  - e. patient's perception of what might be handled differently

N. Performance Standards:

1. Staff who place patients in restraints will have documented training in an approved RPC behavior intervention course in the proper techniques and in less restrictive alternatives to Restraint.
2. Continuous Performance Improvement studies of restraint data provide

the basis for measuring compliance to restraint policy and performance standards. Any new restraint devices or techniques to be implemented by the hospital will be reviewed and thoroughly researched consulting with outside facilities in order to provide recommendations for effectiveness and appropriateness of its utilization. Based on thorough review of the recommendation by the Medical Executive Committee and the Executive Leadership Committee, a decision is made regarding hospital implementation.

O. **Equipment Maintenance:**

Restraint devices are examined semi-annually by the Behavior Response Committee to assure safety in utilization. Restraints are cleaned after every use. Single room care spaces are cleaned after each use. Mattress and floors are washed, walls are washed and clean SECLUSION blankets are placed on mattress. If the room is used as a quiet room then the room shall be cleaned as above. A safety assessment of the room is completed: 1) mats are whole and intact, 2) no foreign objects are present.

- IV. **RESPONSIBILITY:** All Staff
- V. **POLICY STORED IN:** Superintendent's office
- VI. **POLICY APPLIES TO:** Riverview Psychiatric Center Direct Care Staff
- VII. **KEY SEARCH WORDS:** Seclusion and Restraint

ATTACHMENT D

**DOROTHEA DIX PSYCHIATRIC CENTER**

**HOSPITAL WIDE  
DEPARTMENT**

**DATE:** November 2014

**PROCEDURE:** I-8

**SUBJECT:** Seclusion and Restraint

**PERFORMED BY:**

All staff trained in the Mandt System of Behavior Management (Intermediate level or above).

**PURPOSE:**

To establish a hospital policy and procedural guidelines governing the use of seclusion and restraint interventions used for a patient who is at imminent risk of harming him/herself or others and less restrictive interventions have been ineffective to protect the patient or others from harm.

**PHILOSOPHY:**

Dorothea Dix Psychiatric Center is committed to preventing, reducing and supporting patient's rights to be free from seclusions and restraints. We maintain a culture of respectful, least restrictive interventions to maintain safety for all by using nonphysical interventions to deescalate potentially dangerous situations. All staff is trained to meet these expectations through initial and annual trainings that focus on compassionate and respectful safety management. DDPC staff performs ongoing individualized assessments of patients to appropriately target treatment interventions to prevent the need for restraint or seclusion.

**DEFINITIONS:**

1. **Seclusion** is the involuntary confinement of a patient in a room or area whether locked or unlocked from which the patient is physically prevented from leaving. A situation in which a patient is restricted to a room alone and staff are physically intervening to prevent the patient from leaving the room or giving the patient a message that physical intervention will be used if the patient attempts to leave the room are considered seclusion. Seclusion is accomplished by separating the patient from other patients and the unit milieu for safety reasons.
  - a. **Locked door seclusion** is the placement of a patient alone in a locked room or area from which the patient is physically prevented from leaving.
  - b. **Open door seclusion** is instructing a patient to remain alone in a room or area from which the patient is prevented from leaving, however, the door remains open. This is a less restrictive measure than "locked seclusion" however; all requirements for "locked seclusion" remain.

*When the patient moves willingly, without staff coercion to a quiet or sensory room, or any unlocked room on the unit, it is not open door seclusion. A 'time out' is not open door seclusion. A 'time out' is a treatment intervention, not an emergency safety intervention; in which the patient consents to being alone in a designated area for an agreed upon timeframe*

*from which the patient is not physically prevented from leaving. The parameters for the use of time outs must be outlined, documented and consented to in the patient's individualized treatment plan document (see [Nursing Procedure T-65](#)).*

2. **Restraint** is any manual method or physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; **or** a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.
  - a. **Physical Restraint** is the holding of a patient in a manner that restricts his/her movement. Physically holding a patient during a forced psychotropic medication administration is considered physical restraint. Physical restraint is not:
    - Holding a patient to ensure compliance with treatment or procedures that are freely and voluntarily consented to by the patient is not physical restraint.
    - Brief use of the hand or arm to make physical contact with a patient as a means of redirecting or deflecting is not physical restraint.
    - The temporary physical holding of a patient to permit the individual to participate in activities of daily living (ADL) without the risk of physical harm to them is not physical restraint.
    - Having a patient hold on to a staff member or a staff member holding on to a patient to steady and support them while standing or walking to keep the individual from falling or slipping is not physical restraint. The staff member doing this must follow the lead of the patient and release the patient when they no longer require assistance.
  - b. **Mechanical Restraint** is the use of any device that restricts a patient's movement. Use of a device such as a strong gown, tray chair, bed restraints or net is mechanical restraint.
  - c. **Chemical Restraint** is the administration of a drug or medication when it is used as a restriction to manage the patient's behavior and is *not* a standard treatment or dosage for the patient's condition.

*When a medication is administered in an emergency situation against the patient's wishes but the medication is used within FDA approved parameters for the patient's condition, it is an Emergency Medication, not a chemical restraint. The administration of Emergency Medications must follow the rules for Emergency Medication as described in the Rights of Recipients of Mental Health Services and applicable DDPC discipline specific procedures (see [Med Staff Procedure # 9](#) and [Nursing Procedure M-75](#)).*

**POINTS TO BE EMPHASIZED:**

1. Each patient has the right to be free from seclusion and restraints of any form. Seclusion or restraint may only be employed in the following situations:
  - a. If less restrictive measures have proven to be ineffective in de-escalating the situation and protecting the patient or others from harm.
  - b. As an emergency measure reserved for those situations in which a patient's behavior is violent or aggressive and where the behavior presents an immediate and serious danger to the safety of the patient or others.
2. The use of seclusion or restraint will be ended as quickly as possible based on an individualized assessment and re-evaluation of the patient's condition. The patient will be

informed of the conditions for safe release to engage them in minimizing the use of the seclusion or restraint.

3. Seclusion or restraint must never be used as punishment, coercion, discipline, for convenience or retaliation by staff. The destruction of property or disruption of the therapeutic environment alone does not justify the use of seclusion or restraint. The use of seclusion or restraint, or any use of force, as punishment or beyond what is necessary to manage the patient and maintain a safe and therapeutic environment shall constitute patient mistreatment and will be handled according to 1-9 Mistreatment and Other Allegations.doc
4. The use of seclusion or restraint for the prevention of falls should NOT be considered a routine part of a falls prevention program.
5. Seclusion or restraint must never serve as a substitute for adequate staffing to maintain patient safety.
6. To ensure that the potential emergency use of seclusion or restraint will not unduly harm or traumatize the patient, all patients are assessed both for risks related to physical conditions and risks related to trauma history at the time of admission.
7. Each patient (as well as guardian and family/supports as appropriate) will be informed of the DDPC policy regarding use of seclusion and restraint, and be asked to identify who should be contacted in the event of the need for this intervention as a part of the notification of rights at the time of admission.
8. Staff will contact the guardian and any person who has been identified by the patient as a support at the time of the seclusion or restraint to report its use and elicit information that could be helpful in preventing future need of seclusion or restraint.
9. Whenever seclusion or restraint is used, the patient's treatment and management will be reassessed and reviewed and treatment interventions updated as appropriate.
10. Injuries or deaths during or in relation to the use of seclusion or restraint are treated as Sentinel Events and are reported as described in the DDPC Policy 3-34 on Sentinel Events. Deaths associated with the use of restraints are also reported to CMS.
11. DDPC utilizes the MANDT System of Behavior Management and ALL holds should be within the MANDT System whenever possible.
12. All patients must be assessed and examined to rule out any treatable, organic or physical conditions causing the dangerous behaviors before being placed in seclusion or restraint. If the physician is not immediately available to examine the patient, the patient may be placed in seclusion or restraint following an examination by a registered nurse, if the registered nurse finds that the patient poses a risk of imminent harm to self or others. The examination by the registered nurse shall be conducted in accordance with the Seclusion and Restraint Protocol that has been reviewed and approved by the DDPC Medical Staff. The protocol must be completed at the time of the seclusion or restraint, or as soon as clinically possible. The Physician, Nurse Practitioner or Physician Assistant shall perform a face to face evaluation of the patient within 1 hour and document this evaluation.
13. The Clinical Director will be notified immediately by the CNM or NS if a patient:
  - a. Remains in seclusion or restraint for more than 12 hours.
  - b. Experiences two or more separate episodes of restraint of any duration within a twelve hour period.

## PROCEDURE

1. During the admission process it is the responsibility of the admitting RN, in consultation with the patient, to discuss and document the methods, which are helpful to the patient in decreasing feelings of distress in an attempt to prevent situations, which may necessitate seclusion and/or restraint (Reference page 22-23 of the Universal Assessment).
2. To ensure that the potential emergency use of seclusion and/or restraint will not unduly harm the patient, the admitting RN is responsible for completing the Seclusion and Restraint Risk Assessment and notifying the physician of any possible risk factors (Reference page 21 of the Universal Assessment).
3. DDPC Staff will consistently and therapeutically communicate with patients encouraging them to participate, as able, in all forms of recommended treatment. Staff will be vigilant to signs of impending crisis and assist patients in utilizing their skills and strengths to de-escalate.
4. Upon observing violent or aggressive behavior, staff will attempt to help the patient re-gain control by re-directing to an alternate location or activity; talking with the patient or notifying the RN. The RN will assess for the possible need for PRN medication.
5. The use of a seclusion or restraint must be authorized prior to its initiation by a physician, nurse practitioner or Physician Assistant. In some situations, however, the need for a restraint or seclusion intervention may occur so quickly that an order cannot be obtained prior to the application of restraint or seclusion. In these **emergency application situations any staff trained in the MANDT System of Behavior Management** can initiate a physical restraint or seclude a patient (an RN must be made aware immediately). The RN must obtain an order either during the emergency application of the restraint or seclusion, or within 15 minutes after the restraint or seclusion has been applied. The failure to immediately obtain an order is viewed as the application of restraint or seclusion without an order. Only a physician, Nurse Practitioner, Physician Assistant or Registered Nurse have the authority to discontinue the use of seclusion or restraint after an individualized assessment of the patient is completed and it's determined that the need for seclusion or restraint is no longer present, or that the patient's needs can be addressed using less restrictive methods.
6. When least restrictive interventions fail to help manage a situation safely and a patient's behavior continues to pose an immediate risk of safety to the patient, staff members or others the RN will report the event/assessment to the Physician, Physician Assistant or Psychiatric Nurse Practitioner to obtain an authorized order for a physical restraint.
7. Other staff, as able, are alerted to elicit their assistance in safely restraining the patient via a physical hold.
8. During the restraint staff will talk to the patient to inform him/her of the reason for the restraint, behavior needed for release and to assist the patient in returning to a pre-crisis level.
9. An additional staff member must be present during a physical restraint to observe the patient for signs of distress. If an additional staff member is unavailable, the staff member holding the patient must make every effort to observe the patient for signs of distress.
10. The RN may determine that the patient continues to pose an imminent risk of harm to self or others and in collaboration with the Physician, Physician Assistant or Psychiatric Nurse Practitioner obtains an order that authorizes the patient be placed in seclusion or mechanical restraint.

11. The RN assesses ALL patients in seclusion or restraints using the Seclusion & Restraint Protocol (Form # 470) and briefly explains to the patient reasons for seclusion or restraint and conditions for release.
12. When a **Mechanical Restraint** is used:
  - a. Additional staff will set up the bed in the observation room with the head of the bed facing inward and restraint equipment assembled.
  - b. An additional staff member should be present during a restraint to observe the patient for signs of distress. If an additional staff member is unavailable the staff members placing the patient in restraints should observe the patient for signs of distress.
13. When a patient is in **Seclusion**:
  - a. Patients may be asked to remove belts, shoes, jewelry, and the contents of their pockets to ensure patient safety. If the RN finds there is imminent danger that the patient will misuse some article of clothing to injure him/herself, a doctor's order may be obtained to remove the patient's clothing and place the patient in a strong gown.
14. **Seclusion and Mechanical Restraint Monitoring**
  - a. The patient will be kept under constant observation 1:1. The staff observing the patient must document 15 minute checks of modality in use, patient respirations, patient location, and patient behaviors on form #407.
  - b. The patient is released at least every two hours for an assessment in person by the RN to determine whether the patient is an imminent danger to self or others and also to eat, drink, bathe, toilet and to meet any special needs. If the patient is in a mechanical restraint and is unable or unwilling to exercise limbs, ROM should be done during release. Document release activity and level of staff assistance on forms #470 and form #407.
  - c. Patient requests for foods/fluids and bathroom breaks in between the two hour breaks should be assessed by an RN and honored if justified. Any breaks between the two hour breaks are considered additional breaks. These should be documented in the patient's progress notes.
15. **Strong Gown Placement**
  - a. In order to insure that privacy is protected to the greatest extent possible, in light of treatment needs, staff may remove a patient's clothing only under the direct personal supervision of an RN and with a doctor's order. In addition, a same sex staff member must also be present.
  - b. Following the nursing assessment and doctor's order, the patient's ordinary clothing may be removed and a strong gown provided if the RN determines that there is imminent danger that the patient will misuse some article of clothing to injure him/herself. The following factors must be considered: a) whether the patient is threatening self-harm at the time of seclusion. b) Whether the patient has made at least one documented attempt to harm him/herself with ordinary clothing (e.g. by tearing or twisting it) so as to create a potentially dangerous item.
  - c. Offer the strong gown to the patient and encourage him/her to put it on himself/herself.
  - d. If the patient is not adherent with the request, remove the patient's clothing maintaining dignity with use of strong blanket while explaining to the patient what you are doing and why. A same sex member must be present.

16. Release from seclusion or restraint will be based on the Physician, Nurse Practitioner, PA or RN assessment and the conditions for release documented on Seclusion or Restraint Form #470.

#### DOCUMENTATION RN/MHW

1. Whenever a Code 88 is called, an Incident Report form must be completed.
2. Staff informs the patient of conditions for release and provides assistance to the patient in meeting behavior criteria for the discontinuation of restraint.
3. It is imperative that the staff member assigned to 1-1 monitoring of the patient in seclusion or restraint inform the RN as soon as the patient meets the conditions for release so the patient can be released from the restraint as soon as possible.
4. When a telephone order is obtained by the RN. The order is to be entered into the chart Form 123R "restraint orders" or Form 123S "seclusion orders" and must include:
  - a. The date of the seclusion or restraint
  - b. The time of the seclusion or restraint
  - c. The duration of the seclusion or restraint.
  - d. The condition for release.
5. If a Physical Restraint was used prior to seclusion or restraint the Physical Restraint must be indicated on the Seclusion and Restraint Protocol form #470.
6. Seclusions and Restraints are documented on the Seclusion and Restraint Protocol Form #470 and the Seclusion & Mechanical Restraint Assessment and Monitoring form #407. It is imperative that both forms accurately document changes in the restraint event. Communication between the RN completing the restraint assessment and the staff member completing the 15 minute checks is critical to assure that the patient is released from restraint at the earliest possible time.
7. Patients in restraint are assessed by the RN hourly. This assessment includes, as appropriate to the type of restraint employed:
  - a. Signs of any injury associated with the application of restraint
  - b. Nutrition/hydration
  - c. Circulation and range of motion in the extremities
  - d. Vital signs
  - e. Hygiene and elimination
  - f. Physical and psychological status and comfort
  - g. Readiness for discontinuation of restraint
8. A progress note is entered into the patient's medical record by an RN using Form 408 "Nursing Seclusion/Restraint Progress Note".
9. Physical Restraint: The physical restraint is documented by an RN on the top portion only of the Seclusion and Restraint Protocol Form (form #470). A progress note is entered into the patient's medical record by an RN using Form 408.
10. Seclusion/Mechanical Restraint Patients will be continually monitored during the restraint event to ensure the patient's physical safety.
  - a. Patients in a mechanical restraint must be continuously monitored throughout the restraint event face to face by an assigned staff member. Patients in seclusion must be continuously monitored throughout the seclusion event face to face by an assigned staff member for the first hour and until the physician, Nurse Practitioner or Physician Assistant examines the patient and then via continuous audio/video monitoring. This

monitoring is documented in 15 minute increments on form #407 throughout the seclusion/restraint. Respirations are monitored and documented at 15 minute intervals on form #407 throughout the restraint.

- b. The need for a patient's continuation in seclusion/restraint shall be evaluated at least every hour by a registered nurse to assess whether the patient continues to pose a danger to self or others. The registered nurse shall examine the patient in person. The examination may be conducted in or out of seclusion room/mechanical restraint. The registered nurse shall note the clinical reasons for assessing in or out of the seclusion room/ mechanical restraint. If no further dangers are identified, and the patient meets the conditions for early release; the patient shall be released even if the time limited order has not lapsed.
- c. The patient shall be released at least every two hours for an assessment in person by the RN to determine whether the patient is an imminent danger to self or others and also to eat, drink, bathe, toilet and to meet any special needs. When a patient is in a mechanical Restraint, if the patient is unable or unwilling to exercise limbs, ROM should be done during release. Document release activity and level of staff assistance on forms #470 and form #407. A patient's requests for foods/fluids and bathroom breaks in between the two hour breaks should be assessed by an RN and honored if justified. Any breaks between the two hour breaks are considered additional breaks. These should be documented in the patient's progress notes.
- d. Release from seclusion/mechanical restraint will be based on RN assessment and the conditions for release documented on Seclusion and Restraint Form #470.
- e. If danger persists and the order is due to expire, a new order and documentation (Form #470) must be initiated. Any order for an extension of seclusion/mechanical restraint shall include reevaluation and documentation as for an original order. Indicate the need for continuation of seclusion or restraint on the Seclusion and Restraint Protocol form (form #470) by checking "yes" on the Seclusion/Restraint signature line and writing continued in the Time Seclusion/Restraint Ended box at the bottom of form #470.

#### **DOCUMENTATION PHYSICIAN/NURSE PRACTITIONER/ PHYSICIAN ASSISTANT**

1. The decision to place or continue patient placement in seclusion restraint shall be made by a physician, psychiatric nurse practitioner or physician assistant and shall be entered as a medical order in the patient's record.
2. The order for seclusion or restraint cannot be written as a PRN order or as an intermittent order. The following must be included in the order:
  - a. The time of the order
  - b. The type of restriction used: Physical Restraint, Seclusion, Mechanical Restraint
  - c. The maximum number of hours the patient may be secluded or restrained (not to exceed 4 hours for adults, 2 hours for youth aged 9-17)
  - d. The patient's behaviors/conditions under which the patient may be released earlier are included in the order after the Physician/PA and RN collaboratively determine what behaviors the individual needs to demonstrate for safe return to the milieu.
  - e. Any order for an extension of seclusion shall include reevaluation and documentation as for an original order. 3
3. As soon as possible, but within one hour of initiation (or renewal beyond 4 hours) of seclusion or restraint, the Medical Staff must evaluate the patient in person and write a progress note. The evaluation of the patient and progress note, at a minimum must include:

- a. An assessment of the patient's immediate situation, medical stability and mental status while in seclusion or restraint to ensure they are not being compromised by the safety restriction;
  - b. the patient's reaction to the intervention;
  - c. the patient's behavioral condition; and
  - d. an assessment of the need to continue or terminate the seclusion or restraint.
4. The order, evaluation, and progress note documentation are all required even if the seclusion or restraint is terminated by the time the physician, Psychiatric Nurse Practitioner, or PA does the face-to-face evaluation.
  5. When a PA conducts the required face-to-face evaluation, he or she must consult the attending physician or delegated designee within 1 hour of its completion to discuss the findings of the 1-hour face-to-face evaluation, the need for other interventions or treatments, and the need to continue or discontinue the use of restraint or seclusion. This is documented in the progress note.
  6. Renewal of an order for seclusion or restraint beyond the time limit defined in the previous Doctor's Order (usually 4 hours) requires that the Med Staff follow all the steps required for a first time order for seclusion or restraint.
  7. Repeated, continuous use of seclusion or restraint: A single episode of seclusion or restraint may not be repeatedly renewed beyond 24 hours unless:
    - a. The patient is reassessed in accordance with the procedure described above,
    - b. The Medical Director or designee examines the patient. In cases in which the Medical Director is also the attending psychiatrist, another MD/PNP shall be designated to conduct the examination,
    - c. The order and a progress note meeting the standards outlined above must be entered into the medical record by the examiner,
    - d. The patient's guardian or designee must be notified of the use of seclusion or restraint beyond 24 continuous hours.
  8. Repeated but non-continuous use of seclusion or restraint: If a patient:
    - a. remains in seclusion or restraint for more than 12 continuous hours, or
    - b. experiences 2 or more separate episodes of the need for seclusion or restraint of any duration within a 24 hour period, or
    - c. experiences the need for 8 or more separate episodes of seclusion or restraint within a one month period, the Clinical Director will assign a review of the case to a non-involved Medical Staff member and that review discussed in the Medical Staff meeting. The purpose of this review is to assess whether additional or different resources or treatment interventions are needed to prevent the need for or facilitate an earlier release from seclusion or restraint.

### **NOTIFICATIONS**

The patient's family/guardian is notified promptly of the initiation of seclusion. Family notification is done when the patient has consented to have the family kept informed regarding his or her care and the family has agreed to be notified. This information is found on form #501 Notification of Rights (Oct 2000) and located in the Legal Section of the medical record. The Social Worker is responsible for notification during their working hours; otherwise the nurse will notify the family/guardian. The notification shall include reasons and utilization of seclusion with documentation of this in the progress notes of the medical record. Attempts to notify the family/guardian will be noted by the RN using the Physical Restraint/Seclusion/Restraint stamp for completion of the physician order.

## **DEBRIEFINGS**

1. Staff debriefing is completed by the NS within 8 hours of the seclusion or restraint event using Form 470A and the patient debriefing is completed by the NS within 16 hours of the seclusion or restraint event using Form 470B. The patient debriefing is then placed in the patient's medical record.
2. Should the patient refuse to participate in the initial patient debriefing, the Nursing Supervisor will approach the patient every 4 hours thereafter until the Seclusion/Restraint Focused Treatment Plan Review.
3. If there are multiple episodes for one patient prior to the completion of the debriefing, one debriefing may be done for these episodes. The date and time of each event should be noted on the form.
4. A copy of the Staff Debriefing (Form 470A) along with a copy of the incident report is sent to the Clinical Director and Director of Nursing. The original staff debriefing is given to the Unit CNM/NS. Information from both these debriefings will be collated by the unit CNM/NS and corrective actions taken based on findings (Form 470C).

## **SECLUSION OR RESTRAINT FOCUSED TREATMENT PLAN REVIEW**

1. A seclusion or restraint Focused Treatment Plan Review will be performed within 24 hours of the seclusion and restraint event(s) using Form 470TX.
2. The CNM/NS will bring the debriefings (Part A, B and C) to the Focus Treatment Plan Review to discuss with Treatment Team members. Information from the debriefings, if applicable, will be used to update the patient's treatment plan.
3. If there are multiple episodes before the Focused Treatment Plan Review occurs, the episodes may be reviewed in one meeting and documented on one Focused Treatment Plan Review form (Form 470 TX).
4. A copy of debriefing (A, B, and C) along with a copy of the Focused Treatment Plan is sent to the Risk Manager.
5. The Risk Manager will follow-up with the Superintendent and/or members of the Leadership Team to determine any recommended staff follow-up needed.

## **CLEANING OF SECLUSION ROOM**

1. To be performed by Custodial Workers (during on duty hours) or by direct care staff during Custodial Workers off duty hours as directed by the Registered Nurse.
2. Note and report any damage to the seclusion room that requires attention i.e. malfunctioning lights, damage to the protective window screening or heating unit protectors to Plant Maintenance. During off hours contact Shift Engineer.
3. Report any malfunctioning or damaged seclusion/restraint equipment to the unit Clinical Nurse Manager. During off hours contact Nurse Supervisor.
4. Cleaning of the Seclusion room or restraint is to be done after EACH seclusion or restraint and as needed.
5. Remove soiled strong blanket and send to laundry for cleaning.
6. Remove mattress and wash with an EPA registered hospital grade cleaner/disinfectant before re-use.
7. Areas contaminated with body fluids or waste will be cleaned with an EPA registered hospital grade cleaner/disinfectant.

8. Wash floor with an EPA registered hospital grade cleaner/disinfectant.
9. Open window for 10-20 minutes to provide ventilation.
10. Return cleaned mattress and replace strong blanket.
11. Launder seclusion/restraint equipment after each use.
12. If applicable, clean seclusion room bathroom with an EPA registered hospital grade cleaner/disinfectant.

### **PERFORMANCE REVIEW OF THE USE OF SECLUSION**

1. All use of seclusion or restraints shall be reported to the Clinical Director (via Staff debriefing and incident report) for review and investigation of unusual or possible unwarranted usage.
2. If a patient is in S/R more than 8 times in one month, or more than 12 continuous hours, or two or more separate episodes within 24 hours the Clinical Director will call a case review. Information is originated from staff's documentation in the medical record and from the Seclusion and Restraint Form #470.
3. Secluded or restrained patients, episodes and hours utilized from the chart documentation and forms is aggregated monthly by the Performance Improvement Office and reported to Medical Staff. Quarterly aggregated S & R data is reported at IPEC and the Governing Board.
4. Patient specific, coded data is transmitted electronically to the Joint Commission via an approved vendor (National Association of State Mental Health Program Directors Research Institute, Inc.) as our participation in the Oryx Initiative. Benchmark data is reviewed and DDPC practices are assessed in view of other State Mental Health Institute rates to aid in the development of best practices and reduce utilization to an irreducible minimum while maintaining staff and milieu safety.

### **TRAINING**

1. DDPC utilizes the MANDT System of Behavior Management and ALL holds should be within the MANDT System whenever possible.
2. DDPC MANDT instructors are all certified to teach/instruct staff on the MANDT System of Behavior Management.
3. All DDPC direct care staff receives MANDT training at New Employee Orientation, and annually.
4. All DDPC direct care staff receives CPR and First Aid training at new employee orientation and every 2 years.
5. At a minimum, Physicians, Nurse Practitioners and Physician Assistants authorized to order Seclusions and restraints have a working knowledge of DDPC's policy related to the use of seclusions and restraints.
6. All DDPC Nursing Staff receive annual training in the application of Mechanical Devices (AMD).

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